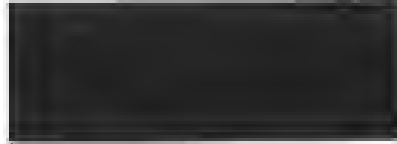




University of Connecticut
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Name
MRN:



CLINICAL RECORD - INPATIENT

11/26/2012	ICU APRN Admission Note	ICU day #1; HD #1
<p align="center"><u>CC/HPI</u></p> <p>Mr. [REDACTED] is a 76 yr old Caucasian male with a PMH of DM, HTN, and CAD who underwent a cardiac workup prior to carpal tunnel surgery, ultimately resulting in a cardiac catheterization revealing severe three-vessel coronary artery disease with a normal left ventricular function. He reported symptoms of dyspnea on exertion, but no CP otherwise. Today he underwent a CABG x4 (Circ --> diag LIMA-->LAD). Postoperatively he was transferred to the ICU intubated and sedated, and epinephrine and neosynephrine infusions running. He received in total of 2L NS boluses throughout the afternoon, and neosynephrine was quickly weaned to off. Epinephrine has been transiently on and off at low doses to maintain a MAP >65, and the patient was weaned and extubated early this evening. He was oxygenating well on 4L NC O2. After falling asleep, he was placed on his home Bipap settings of 12/5 with RA. He currently remains on low dose epinephrine, and he is resting comfortably in bed with the Bipap mask in place.</p> <p align="center"><u>Intra-Op Course</u></p> <p>Difficult intubation, no problems placing on and off CPB, total CPB time: 151, xclamp time: 121, normal LV function post CPB, defib x2, cell saver 950mL, 2200mL crystalloid, no blood products, 500mL UO, off CPB on epinephrine and neosynephrine infusions post-op, initially AV paced rate of 80.</p>		

<p align="center"><u>PMH:</u></p> <p align="center">C. Diff colitis DM HTN BPH Hyperlipidemia GERD Renal Insufficiency Sleep apnea (on home Bipap 12/5 with RA) Basal cell carcinoma s/p resection</p>
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<p align="center"><u>PSH:</u></p> <p align="center">Gallbladder removal Basal cell carcinoma resection</p>
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Social:

Pt was born in Scotland. He is married with 3 children, one of whom had CABG at age 42. He is independent in his ADLs. He is not employed and reports a 10yr history of smoking 10 cigarettes/day but quit >35 yrs ago. He does not report current ETOH, tobacco, or illicit drug usage.

FH:

Per documents in chart, pt's mother and father died of cancer. His brother also had cancer from occupational hazards/asbestos exposure.

ROS:

Deferred secondary to intubation and sedation

Home Meds:

(per documentation in chart)

Amlodipine 5mg PO qAM

Aspirin 325mg PO daily

Finasteride 5mg PO daily

Glyburide 1 tab PRN glucose >140

Lisinopril 20mg PO daily

Nebivolol 10mg PO qAM

Pantoprazole 40mg PO daily

Simvastatin 20mg PO qHS

Tamsulosin 0.4mg PO qAM

Allergies:

NKDA

Diagnostics:

11/5/12 Carotid Doppler: 1. The bilateral internal carotid arteries reveal no evidence of significant stenosis.

2. The external carotid arteries reveal no significant stenosis. There is mild degree of stenosis involving both carotid bifurcations. This is due to mild to moderate heterogeneous plaque in the right carotid bulb and distal right common carotid artery as well as moderate heterogeneous plaque in the left carotid bulb. There is

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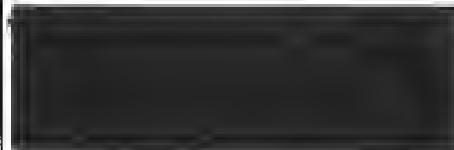
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also mild non-calcified plaque in the distal left common carotid artery. These are NOT hemodynamically significant. 3. The bilateral vertebral arteries are patent with normal antegrade flow. 4. The bilateral subclavian arteries reveal no evidence of significant stenosis.

Cardiac Cath:

(per outpatient notes from Waterbury Hospital)

Date of study: 10/23/12 Impressions: 1. Left main artery large in size with mild disease. 2. Left anterior descending artery with 90% proximal stenosis, mid segment with 90-95% stenosis. The distal vessel is large with moderate disease. D1 & D2 are at the proximal and mid segments right at the previously noted stenosis. They are both calcified with 80 to 90% ostial stenoses. 3. Left circumflex artery is a large dominant system. OM1 is small, OM2 branching large vessel. Lower branch of this vessel with 80 to 90% stenosis. distal to this a 70 to 80% stenosis in the left circumflex artery prior to the take off of large left posterolateral branch, which has mild disease and LPDA is also moderate to large in size with 80 to 90% proximal stenosis. 4. RCA is small nondominant vessel with 95% proximal stenosis. 5. LVFF of 60%.

T _{spO2}	P	RR	BP	SaO2	CVP
97.4	02 SR	14	111/52 (70)	96% on 40% FIO2	16

MODE	Rate	TV	FIO2	PEEP	SAO2
AC	14	600	40%	5	96%

Exam

General: Intubated, sedated pale Caucasian male lying in bed in no acute distress

HEENT: Normocephalic, atraumatic; pupils equal and sluggishly reactive, 3 mm constricting to 2mm, sclera injected, + chemosis, oral mucosa pink and moist, no leukoplakia but small purple area on L tip of tongue, OGTT in place to LCWS, #8 ETT at 24cm at the lip

Chest: Midline sternal incision, edges intact and approximated open to air, no drainage noted, 2 mediastinal and 1 pleural CT to 20cmH2O wall suction, no air leak noted, all draining very small amount thin sanguinous drainage to chamber

Neck: Supple, trachea midline, 2+ carotids, no bruit auscultated, no JVD appreciated, R IJ cordis with site in place, site benign, dressing CDI

Heart: RRR, S1 soft, S2 soft with + pericardial rub auscultated loudest at 5th ICS, L sternal border, no murmur or gallop appreciated, PMI 5th ICS, MCL, no lifts or heaves

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Lungs: Clear throughout with decreased breath sounds in bilateral bases, no wheezes or ronchi noted

Abd: Soft, no grimace to palpation, + but hypoactive BSs throughout, no organomegaly appreciated, tympanic to percussion.

GU: Foley to gravity with clear yellow urine, external anatomy normal in appearance.

Extremities: Warm upper extremities with 2+ pulses in radials, Doppler pulses bilateral pedal pulses with LEs slightly cool and pale, nail beds pale with 3 second capillary refill, no clubbing, multiple small bruises on fingertips, trace to 1+ UE edema and +3 pitting LE edema, R radial artery site benign, dressing CDI, R leg with ace wrap and hemovac extending from beneath, hemovac to self suction with trace serosanguinous drainage in tubing

Neuro: Assessment limited secondary to sedation, but pt will nod and follow simple commands, and moves all extremities to touch. No facial droop or ptosis appreciated.

Labs

Pre-Op CABG

11/20/12 1155

141	107	25	Gluc	iCa	1.25	WBC	H/H	Ptt	Bands	PT	12.0
4.6	27	1.6	181	PO4	3.9	12.1	14.3	214		PTT	25.8
				Mag	1.5		41.6			INR	1.1

Fibrinogen: 409

Albumin: 3.0

Bili T/D: 0.6/0.1

Thrombin Time: 16.2

AST: 31

TSH: 1.42

ALT: 32

HgA1c: 6.4

Alk Phos: 91

Post op CABG

11/26/12 1515

141	111	21	Gluc	iCa	1.19	WBC	H/H	Ptt	Bands	PT	15.5
4.4	22	1.4	135	PO4	3.2			125		PTT	28.8
				Mag	1.9		31.6			INR	1.7

Fibrinogen: 214

Thrombin time: 20.3

VENT:	PH	CO2	PO2	HCO3	O2 sat
ABG: AC 14-600-40% - 5 peep	7.32	41	75.1	21.4	94.3%

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Cultures:

none

Diagnostic Tests:

11/26/12 EKG: SR rate 92, PR: 0.16, QRS: 0.12, QT: 0.38; T wave inversion III, AVF, & V1 with ? in II as well, similar to pt's baseline EKG; new incomplete R BBB

11/26/12 CXR: Fair inspiratory effort, overpenetrated, BL effusions v. atelectasis, R IJ cords -> SVC, ETT 5cm above carina, CTs x3, OGT -> below diaphragm (pt extubated shortly thereafter)

ICU Meds

Sucralfate 1 gr QGT Q6hr while intubated

Pantoprazole 40 mg PO daily when intubated

Cefuroxime 1.5 gr IV Q 8 hr X3

Pneumococcal vaccine

Influenza vaccine

Heparin 5000 units SC to start in the am

NS at 50 ml/hr total at drips

RISS

Folic acid 1 mg PO daily

Thiamine 100 mg PO daily

Cyanocobalamin 250mcg PO daily

Ascorbic acid 500 mg PO daily

Ferrous sulfate 324 mg PO TID

Docusate 100 mg PO BID

Epinephrine infusion

Tamulosin 0.4mg PO qAM

Finasteride 5mg PO daily

Atorvastatin 20mg PO qPM

PRN: hydromorphone, midazolam, ondansetron

Lines:

R IJ Cordis with sliC (inserted 11/26/12): Dressing CDI, site benign

R radial a-line (inserted 11/26/12): Dressing CDI, site benign

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Assessment & Plan
Mr. [REDACTED] is a 76 yr old male s/p CABG x4, admitted to the ICU for continued hemodynamic and respiratory management.
Neurological: No focal deficits. Pain control → hydromorphone PRN with good effect. Activity → COB to chair on POD #1.
Cardiovascular: CAD s/p CABG x3 → pt currently requiring epinephrine infusion to maintain MAP >65. Utilize gentle volume resuscitation with small NS boluses to attempt to reduce epinephrine requirements. If needed for further pressor support, may consider restarting norepinephrine infusion. A & V pacer wires attached to pacemaker with backup rate of 60. CT output minimal; continue to monitor closely. Hx of HTN, however not a current issue → home antihypertensives on hold. If SBP increases >140 off of pressors, restart home antihypertensives and consider initiating nitroglyceride if necessary to keep SBP <140 to protect grafts. On aspirin 324mg PO daily for graft patency. Restart beta blocker tomorrow for arrhythmia prophylaxis once off pressors and hemodynamically stable. Hx hyperlipidemia → home atorvastatin restarted.
Pulmonary: Pt extubated to 4L NC O2 this evening and continues to oxygenate well, maintaining O2 sats >94%. Wean oxygen as tolerated to RA to maintain O2 sats >94%. IS q 1 hr and good pulmonary toileting. Hx OSA → on home Bipap qHS and while napping.
FER: Hx of renal insufficiency, creatinine post-op 1.4. Monitor daily, avoid nephrotoxins, and maintain MAP >65 for adequate renal perfusion. IVF with NS for total all gts of 50mL/hr. Calcium & magnesium repleted. Repeat lytes at 9pm and again in AM; replace to maintain K+ >4.0, Mg+ >2.0, and iCa+ >1.2 for arrhythmia prophylaxis.
GI: Advancing diet as tolerated to cardiac 2gm Na+, 60gm fat, no concentrated sweets. Hx of GERD → on pantoprazole, Ondansetron PRN nausea, Hx of c. D. colitis → no diarrhea at this time; continue to monitor.
GU: Hx of BPH → restarted on home tamsulosin and finasteride.
Endocrine: Hx of DM → Fingersticks q4hrs with RISS coverage. For two consecutive FSGs >180, initiate insulin infusion for improved glycemic control. TSH WNLs in pre-op bloodwork.
ID: Periop prophylaxis with cefuroxime x3 doses.
Hematology/Oncology: Acute blood loss anemia secondary to surgical procedure → will continue to monitor Hct at 9pm and again in AM. If Hct <24, notify surgeon prior to transfusing. Coagulopathy → coags mildly elevated postoperatively but CT drainage minimal and no s/s appreciable bleeding noted. Continue to monitor.





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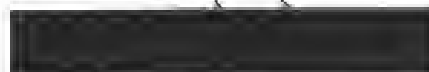
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Prophylaxis: DVT prophylaxis → PAS, heparin SC to start POD #1 GI prophylaxis → sucralfate while intubated, then pantoprazole in the AM VAP prophylaxis → HOB >30 degrees, frequent oral care

Disposition [REDACTED] continues to require hemodynamic and respiratory monitoring and ICU level care s/p CABG. He was seen and discussed with [REDACTED] He is a full code. His family was updated at the bedside.



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